

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9361

08940

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County

Cecil

City or town

Chesapeake City Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Gertrude E. Adams

7. Birth date of deceased (mo., day, yr.)

2 - 16 - 1874

6. (c) If alive, give age 71 years

8. AGE:

72

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Ashley &amp; his

(town, county, and state)

10. Usual occupation

Showman

11. Industry or business

12. Name

James Adams

13. Birthplace

Ohio

14. Maiden name

Rosebell Westbrook

15. Birthplace

Ohio

16. Informant

Mrs James Evans Adams

Address

Chesapeake City Md

17. Burial

Date thereof Sept 4-1941

(month) (day) (year)

Burial, cremation, or removal. Which?

Bethel

Cemetery or crematory

C Chesapeake City Rural Md

Location

C Chesapeake City Rural Md

18. Funeral director

Joseph R. Glenn

Address

North East Md

19. Date rec'd by Registrar

Sept 4-1941

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Cecil

City or town

Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

not a veteran

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 2

1946

af

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 19 1946 to Sept 2 1946

and that I last saw him alive on Sept 1 1946

DURATION

Pulmonary infarction 2 week

Due to Hypertension Cactus-wash larva

5 years

Due to

Other conditions Pasture left hemiplegia 3 years

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

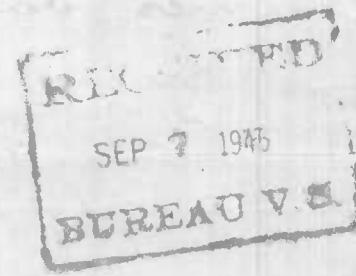
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. D. Doris MD M. D. or other

Address Chesapeake City Md Date signed 9/2/41

Registrar



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

2411 N. Charles St., Baltimore 3-29

08941

File No. I 07 OCT 8 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

~~(X)~~ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Cecil  
 City or town Colona  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Colona  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) Spanish American

3. (a) FULL NAME  
Custer Kemp Brown

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Alice Brown

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1877 8. (c) If alive, give age years

8. AGE: Years 68 Months 69 Days 10 If less than one day 21 hrs. hrs. min. min.

9. Birthplace Colona, Cecil County, Maryland  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Joseph P Brown  
 13. Birthplace Colona, Md.

MOTHER FATHER

14. Maiden name Alice Matson  
 15. Birthplace Pa.

16. Informal Joseph Brown  
 Address Colona, Md.

17. Burial Burial Date thereof 9/16/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory West Nottingham

Location Colona, Maryland

18. Funeral director Ralph M Reed  
 Address Rising Sun, Md.

19. Sep. 15 1946 L. W. Worthington  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 19 46, at 330 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19,  
 and that I last saw h. alive on 19.

Immediate cause of death leptorrhachic meningitis

Due to lissencephaly

Due to

Other conditions   
 (Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

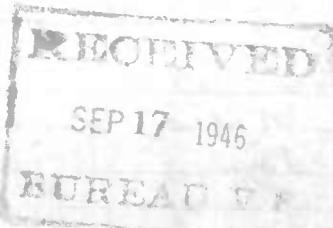
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

23. SIGNATURE B. W. Dodson Jr. Social Examiner  
 M. D. or other   
 Address Colona, Md. Date signed Sept. 14 - 46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160

## CERTIFICATE OF DEATH

Reg. Dist. No. 089492

## 1. PLACE OF DEATH:

County..... Capital  
 City or town..... Elstion  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

16 hrs

## 3. (a) FULL NAME

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
--------	------------------	---

Male	White	Single
------	-------	--------

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
---------	-------	--------	------	----------------------

16	hrs.	7 min.
----	------	--------

9. Birthplace..... Elstion, City, Md.

(Town, county, and state)

10. Usual occupation..... None

11. Industry or business.....

12. Name..... Franklin S. Bryan

13. Birthplace..... Maryland, Md.

14. Maiden name..... Janita Fylett

15. Birthplace..... Little Rock, Arkansas

16. Informant..... Franklin S. Bryan

Address..... Elstion, Md.

17. Burial..... Date thereof..... 9-9-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Methodist

Location..... North East, Md.

18. Funeral director..... Joseph R. Evans

Address..... North East, Md.

19. Sept 9 1946 F. R. Fraser  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... 2nd County..... Capital

City or town..... Elstion  
 (If outside city or town limits, write RURAL and give nearest town)

Street No..... 114 Holburner's Manor  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

Bryan Done

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 7 1946 at 60 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-7-1946 to 9-7-1946 and that I last saw him alive on 9-7-1946.

Immediate cause of death..... Premature

8 min.

Due to.....

Prematurity  
Separation of placenta.

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

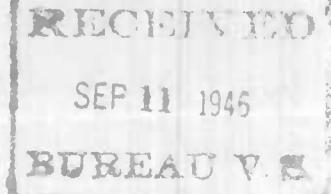
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Old Ocean Rd.  
 Belvoir, Seaford, Del. M. D. or other

Date signed 9/9/46

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 924

08943

## CERTIFICATE OF DEATH

Reg. Distr. No. ....

96

## 1. PLACE OF DEATH:

County ..... **Cecil**City or town ..... **Perryville**

(If outside city or town limits, write RURAL and give nearest town)

**35 years**How long in above place of death? ..... **35 years**

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

## 3. (a) FULL NAME

**Mary Elizabeth Burrows**

4. Sex ..... 5. Color or race ..... 6. (a) Single, married, widowed, or divorced

**Female** **white** **Married**B. (b) Name of husband or wife ..... **Abner R. Burrows**6. (c) If alive, give age ..... **67** years

7. Birth date of deceased (mo., day, yr.)

**Oct. 14, 1878**

8. AGE: Years ..... Months ..... Days ..... If less than one day

**67** **11** **6** ..... hrs. ..... min.9. Birthplace ..... **Cecil Co., Md.**

(Town, county, and state)

10. Usual occupation ..... **House Wife**

## 11. Industry or business

12. Name ..... **Isaac Redgrave**13. Birthplace ..... **Md.**14. Maiden name ..... **Mary E. Roe**15. Birthplace ..... **Md.**16. Informant ..... **Abner R. Burrows**Address ..... **Perryville, Md.**17. Burial ..... Date thereof ..... **Sent. 23, 1946**  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory ..... **Hopewell**Location ..... **Port Deposit, Md. Rural**18. Funeral director ..... **Lula Patterson**  
Address ..... **Perryville, Md.**19. Sept. 23, 1946, Name & Surname ..... **J. Magruder**  
(Date rec'd by registrar) **Registrar**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... **Maryland** County ..... **Cecil**City or town ..... **Perryville, Md.**

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

**September 20, 1946**I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 15, 1946** to **September 20, 1946** and that I last saw her alive on **September 20, 1946**

Immediate cause of death

**Chronic Tuberculosis  
Heart Disease**

DURATION

**15 yrs**

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? ..... (City or town) (County) (State)

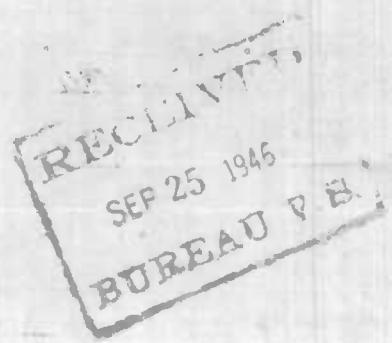
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

**J. Magruder**  
M. D. or other  
Address ..... **Perryville, Md.** Date signed ..... **Sept. 23, 1946**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08944

120

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County

Oxon

City or town

Hilltop - Oxon Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

29 hours

Hospital, institution, or street address where death occurred:

Hilltop Hospital - Oxon Hill

How long in hospital or institution?

29 hours

## 3. (a) FULL NAME

Antonio Calao

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

7. Birth date of

deceased (mo., day, yr.)

July 21, 1888

6. (c) If alive, give age..... 55 years

8. AGE:

58

Years

Months

Days

If less than one day

hrs. .... min.

9. Birthplace

Italy

(Town, county, and state)

Italy

10. Usual occupation

Laborer

11. Industry or business

Penn. Railroad

12. Name

Dingemza Calao

13. Birthplace

Italy

14. Maiden name

Mary S. Devitto

15. Birthplace

Italy

16. Informant

James Calao

Address

Perryville

Md

17. Burial

Burial

Date thereof

Sept 16 '46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Erin

Location

Havre de Grace

Md

18. Funeral director

Les A. Patterson &amp; Son

Address

Perryville, Md.

19. Sept 12 '46

(Date rec'd by registrar)

19

Date

19

Sept 12 '46

Date

19

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Baltimore

City or town

Perryville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

(Calao)

717-07-5485

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12 -

1946 at 34 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 11, 1946 to Sept 12, 1946 and that I last saw him alive on Sept 12, 1946.

Immediate cause of death

Intestinal obstruction

DURATION

Due to Strangulated hernia

Vernia

Due to former operation for

strangulated hernia

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Strangulated hernia -

Intestinal obstruction

Date of op. Sept 11, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

John Paulino M.D. M.D. or other

Address: North Court Rd. Date signed Sept 12 '46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (III-a)

08945

## CERTIFICATE OF DEATH

Reg. Dia. No. 96

## 1. PLACE OF DEATH:

County CecilCity or town Veterans Administration HospitalOutside city or town limits, write RURAL and give nearest town Perry Point, Md.How long in above place of death? 20 years 2 daysHospital, institution, or street address where death occurred: Veterans Administration Hosp., Perry Point, Md.How long in hospital or institution? Same as above

## 3. (a) FULL NAME

CAROUSSOS, Nicholas G.

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Unknown

## 8.(b) Name of husband or wife

6.(c) If alive, give age — years  
7. Birth date of deceased (mo., day, yr.) July 22, 18898. AGE: Years 57 Months 2 Days 5 If less than one day — hrs. — min.9. Birthplace Greece

(Town, county, and state)

10. Usual occupation Unknown11. Industry or business —MOTHER FATHER 12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Hospital Records, Veterans Administra-  
tion, Perry Point, Md.17. Burial Date thereof 10-2-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Pennington & Son  
Address PENNINGTON & SON, Havre de Grace,  
Maryland.19. Oct. 1 1946 Irene Edna Murphy  
(Date rec'd by registrar) Registrant

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State UnknownCounty UnknownCity or town Unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown

(If rural, give LOCATION)

World War I

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1946, 3:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 1946, to September 27 1946, and that I last saw h. im alive on September 27 1946.

Immediate cause of death

Pulmonary Embolism

DURATION

ImmediateDue to —Due to —Other conditions Dementia Precox, Hephrenictype Approx. 28 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results Same as above

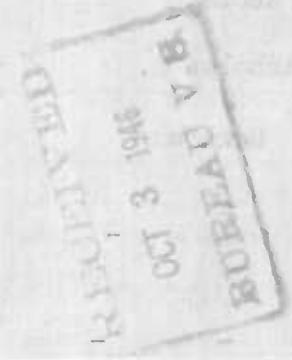
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide —Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, pub'c place (where?) —Means of injury —Injured at work —23. SIGNATURE R. L. Dodeon, M.D.Medical Examiner  
Cecil County

M. D. or other

Address Perry Point, Md. Date signed 9/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age and date of birth is shown  
on

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

FILM No. 108 JU 28 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 089469/

## 1. PLACE OF DEATH:

County

Cecil

City or town

Chesapeake City Md RD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

David P. Fillingame

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

78 60 1864

8. AGE:

82

86

Years

.

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Chesapeake City RD md

(Town, county, and state)

10. Usual occupation

retired merchant

11. Industry or business

John W Fillingame

Chesapeake Md / K D

12. Maiden name

no information

13. Birthplace

Baltimore Md

14. Informant

B F Crouse

Address

Elkton Md RD

17. Burial

Date thereof Sept 23 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Augustine

Location

St Augustine Md

18. Funeral director

H C D Pippin

Address

Elkton Md

19. Sept 23

1946 Date rec'd by registrar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Cecil

City or town

Chesapeake City md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

Sept 20

19

46

at

12:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

appr

19

46

Sept 20

19

46

and that I last saw h... alive on

Sep 19

1946

Immediate cause of death

Chronic Myocarditis

DURATION

years

Due to

old age

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

H. V. Davis MD

M. D. or other

Address

Chesapeake City Md

Date signed

9/23/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5

P8947

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:  
Cecil  
County

City or town..... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 30 yrs.

Hospital, Institution, or street address where death occurred:

Union Hospital, Elkton, Md.

How long in hospital or institution?..... 19 days.

## 3. (a) FULL NAME

Warren E. Malin

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

Male	White	Married
------	-------	---------

8. (b) Name of husband or wife..... Margaret Malin

6.(c) If alive, give age ..... 64 years

7. Birth date of deceased (mo., day, yr.) May 2, 1882

8. AGE: Years Months Days If less than one day

64	5	16	hrs.	min.
----	---	----	------	------

9. Birthplace..... Corner Ranch Del  
(Town, county, and state)

10. Usual occupation..... Lawyer/Magistrate

## 11. Industry or business

12. Name..... John W. Malin

13. Birthplace..... Del

14. Maiden name..... An No. Inf

15. Birthplace..... No. Inf

16. Informant..... Jack Malin

Address..... Kennett Square Pa

17. Burial..... Date thereof..... Sept 18 1946

(Burial, cremation, or removal. Which?) Cemetery or crematory..... Union Hill

Location..... Kennett Square Pa

18. Funeral director..... N.W. Dupper

Address..... Elkton, Md.

19. Sept 18 1946

(Date rec'd by registrar) F.B. Fraser

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... North St.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Sept. 15, 1946, at 1:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 21, 1946, to Sept. 15, 1946,

and that I last saw h. im. alive on Sept. 15, 1946.

Immediate cause of death..... Undulant Fever

DURATION..... 26 days

Due to.....

Due to.....

Other conditions..... Myocardial failure

9-13

Sept. 13, 1946

(Include pregnancy within 3 months of death)

Major findings at operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

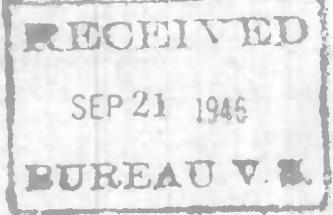
Means of Injury..... Injured at work?

23. SIGNATURE..... Dr. Edward K. Sprecher, M.D.

M. D. or other.....

Address..... Elkton, Md.

Date signed..... 9/17/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

08948

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

**1. PLACE OF DEATH:**  
 County *Baltimore*  
 City or town *Eckles - Md.*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *4 days*

Hospital, institution, or street address where death occurred: *Moor Hospital*

How long in hospital or institution? *4 days*

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)

State *Maryland* County *Baltimore*  
 City or town *Eckles*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

**3. (a) FULL NAME**

*Elsie Phillips*

**3. (b) Social Security Number**

4. Sex *Female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married*

6.(b) Name of husband or wife *Albert Phillips*

7. Birth date of deceased (mo., day, year) *March 11 - 1900* 6. (c) If alive, give age *46* years

8. AGE: Years *46* Months *6* Days *19* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Eckles - Md.*  
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Geo. R. Jones*

12. Name *Geo. R. Jones*

13. Birthplace *Maryland*

14. Maiden name *Elsey D. Thompson*

15. Birthplace *Maryland*

16. Informant *Joseph R. Grant*

Address *Burial* Date thereof *Oct. 1 1946*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *North East Methodist*

Location *North East, Md.*

18. Funeral director *Joseph R. Grant*

Address *North East, Md.*

19. Date rec'd by registrar *Sept. 30 1946* F. R. Fraser Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Sept 29-1946* 1946, at 0450P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Sept 26 1946* to *Sept 29 1946*and that I last saw her *alive* on *Sept 29 1946*Immediate cause of death *Cardiac arrest**Hypertension*Due to *! Hypertension*Due to *! Hypertension*Other conditions *Diabetic**Unknown*

(Include pregnancy within 8 months of death)

Major findings of operations *None*Date of op. *None*Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *J. H. McLaughlin*M. D. or other *None*Address *Eckles - Md.* Date signed *Sept 30 1946*

RECEIVED

OCT 5 1946

BUREAU F B I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

08949

Reg. Dist. No. 94

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Cecil

City or town..... Elkton, Rural

(If outside city or town limits, write RURAL and give nearest town)

29 years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anna Dorothy Reynolds

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Van Reynolds

6.(c) If alive, give age 74 years

## 7. Birth date of deceased (mo., day, yr.)

October 4th, 1877

## 8. AGE:

68

Years

Months 11

Days 21

If less than one day

hrs.

min.

## 9. Birthplace

Perryman, Harford Co., Md

(Town, county, and state)

## 10. Usual occupation

HOUSEWIFE

## 11. Industry or business

## 12. Name

Ernest Schirling

## 13. Birthplace

France

## 14. Maiden name

Caroline Bay

## 15. Birthplace

Germany

## 16. Informant

Van Reynolds

## Address

Elkton Route 1, Md

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 27, 1946

(month) (day) (year)

## Cemetery or crematory

Spesutia Episcopal

## Location

Perryman, Harford Co., Md

## 18. Funeral director

Joseph P. Grant

## Address

North East, Maryland

## 19. Date record by registrar

Sept 26

1946

Lester &amp; Lorraine

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Cecil

City or town..... Elkton, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Sept 25

1946 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 27/46 19 to Sept 2- 1946

and that I last saw him alive on Sept 2 1946

## Immediate cause of death

Pulmonary edema

## Due to

Cerebral edema

## Due to

Fever

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. None

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work

## 23. SIGNATURE

to Dr. C. C. Penick

M. D. or other

Address North East Date signed Sept 26/46

RECEIVED

SEP 30 1945

BUREAU F B I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

08950

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Benj Franklin Riley

4. Sex

M

5. Color or race

Wh

6. (a) Single, married, widowed, or divorced

Married

B.(b) Name of husband or wife

Lacie Smith

5. (c) If alive, give age 75 years

7. Birth date of deceased (mo. day, yr.)

Jan 7. 1 1867

8. AGE:

Years  
79Months  
8Days  
8

If less than one day

hrs. .... min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name

Benj F Riley

13. Birthplace

Md

14. Maiden name

Martha Keithley

15. Birthplace

Md

16. Informant

Lacie Riley

Address

Rising Sun. Md

17. Burial

Burial

Date thereof

Sept 12 1946

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Penn Bell.

Location

Fulton Twp

18. Funeral director

F L Bauffman

Address

Peach Bottom, Pa.

19. Date signed by registrar

19

(Date signed by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

City or town

Rising Sun Rural

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 9

1946 af

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1946 to Sept 9 1946

and that I last saw him alive on Sept 9 1946

Immediate cause of death

Carcinoma  
of stomach.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

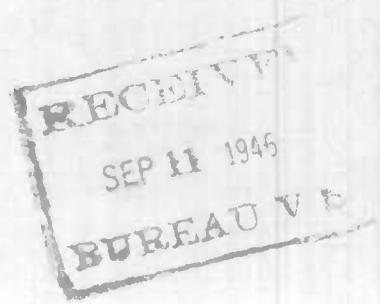
Injured at work?

23. SIGNATURE

John D. Dickey

M. D. or other

Date signed



CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... Cecil

City or town..... Veterans Administration Hosp. Perry Point  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 yrs. 11 mo. 30 da. Md.

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital, Perry Point,  
Same as above Md.

How long in hospital or institution?.....

3. (a) FULL NAME

RUHL, Maurice

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Mrs. Carrie Ruhl

7. Birth date of deceased (mo., day, yr.)

October 19, 1876

Deceased (c) If alive, give age Unknown years

8. AGE: Years

Months

Days

If less than one day

-69-

70

10

16

17

-

hrs.

-

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Railroad truckman

11. Industry or business

MOTHER FATHER

Henry Marshall Ruhl

MOTHER

Maryland

14. Maiden name

Jane Kirk

15. Birthplace

Brooklyn, N.Y.

16. Informant

Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal

Date thereof Sept. 5, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Baltimore, Md.

18. Funeral director

Pennington & Son, Havre de Grace,

Address

Md.

Sept. - 5 - 1946 - Jane E. Langford

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Couoly

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2924 Huntington Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish American

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 4

19 46 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 5, 1939

19

to

Sept. 4

19 46

and that I last saw h. im. alive on

September 4

19 46

Immediate cause of death

Pneumonia, Broncho

DURATION

1 week

Due to

Due to

Other conditions Psychosis with cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Over 7 yrs.

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

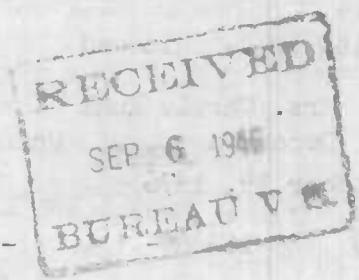
Means of injury

Injured at work

23. SIGNATURE

A. HOLLINGER, M.D. Clinical Director  
Veterans Administration, Perry Point, Md.

Date signed 9/7/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

08952

96

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:	Cecil
County	
City or town	Perryville, Md.
(If outside city or town limits, write RURAL and give nearest town)	
How long in above place of death?	89 Years
Hospital, Institution, or street address where death occurred:	
How long in hospital or institution?	

2. USUAL RESIDENCE (HOME) OF DECEASED:	
(For newborn infants give residence of mother)	
State	Maryland
County	Cecil
City or town	Perryville
(If outside city or town limits, write RURAL and give nearest town)	
Street No.	
(If rural, give LOCATION)	
2.(a) If veteran, name war	

## 3. (a) FULL NAME

Samuel Gale Smith

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Widowed		
6.(b) Name of husband or wife		Emma Morgan Smith		
7. Birth date of deceased (mo., day, yr.)		May 3, 1857		
8. AGE:	Years	Months	Days	If less than one day
	89	4	7	hrs. min.
9. Birthplace		Perryville, Cecil Co., Md.		
(Town, county, and state)				
10. Usual occupation		Teamster		
11. Industry or business				
MOTHER FATHER	12. Name	Thomas Smith		
	13. Birthplace	Cecil Co., Md.		
MOTHER	14. Maiden name	Emily Rodenhi		
	15. Birthplace	Unknown		
16. Informant		Lillian M. Smith		
Address		Perryville, Md.		
17. Burial		Date thereof: Sept. 14, 1946 (Burial, cremation, or removal. Which?)		
Cemetery or crematory		Ashbury		
Location		Port Deposit, Md. Rural		
18. Funeral director		Lee A. Patterson, Jr.		
Address		Perryville, Md.		
19. Date rec'd by registrar		Sept. 12, 1946 Irene E. Daugherty Registrar		

## 3. (b) Social Security Number

X

## MEDICAL CERTIFICATION

20. DATE OF DEATH	September 10, 1946, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from	
and that I last saw him alive on Sept. 10, 1946	
Immediate cause of death	
General Thrombosis	
DURATION	
4 hrs	
Due to	
General Atherosclerosis	
DURATION	
10 yrs	
Due to	
Other conditions	
(Include pregnancy within 8 months of death)	
Major findings of operations	
Date of op.	
Autopsy results	
PHYSICIAN: Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide..... Date of .....	
Where did injury occur? (City or town) (County) (State)	
Injured at home, farm, industry, public place (where?)	
Means of injury	
Injured at work?	
23. SIGNATURE	
M. D. or other	
Address	
J. F. Magruder	
Date signed	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108953

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

## 1. PLACE OF DEATH:

County..... CecilCity or town..... North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 60 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Richard Gustavis Underwood

## 3. (b) Social Security Number

217-16-15004. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Dora B. Underwood6. (c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) November 21 18608. AGE: Years 85 Months 9 Days 16 II less than one day

hrs. .... min.

9. Birthplace Elkton, Rural, Cecil Co., Md  
(Town, county, and state)10. Usual occupation Dentist - Park President11. Industry or business Retired 6 yrs12. Name Bernardina Underwood13. Birthplace Maryland14. Maiden name Mary Callis15. Birthplace Virginia16. Informant Dora B. UnderwoodAddress North East, Maryland17. Burial Date thereof 9-8-46  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory M. ThroostLocation North East, Md.18. Funeral director Joseph P. GrantAddress North East, Md.19. 9-8 1946 Lida & Irene  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town North East  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war Navy 3. Veteran No

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1946, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4 1945 Sept. 6 1946and that I last saw him alive on Sept. 5 1946Immediate cause of death CerebralPneumoniaBronchitis andHypertension

DURATION

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

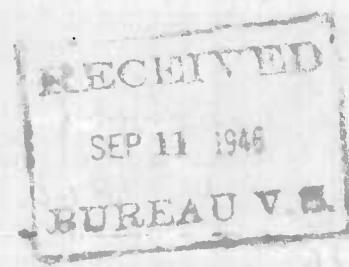
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE O.B. Caccino, M.D. M. D. or otherAddress North East, Md. Date signed 9-7-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-2

18954

96

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

76 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Albert Norris Vannort

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife.....

Rebecca E.

7. Birth date of

deceased (mo., day, yr.)

Sept. 24, 1870

6. (c) If alive, give age

76

years

8. AGE:

Years

Months

Days

If less than one day

6

hrs.

min.

9. Birthplace.....

Port Deposit, Cecil, Md.

(Town, county, and state)

10. Usual occupation.....

Clerk

11. Industry or business

U.S. Veterans Adm.

12. Name.....

John G. Vannort

13. Birthplace

Cecil Co., Md.

14. Maiden name.....

Mary J. Norris

15. Birthplace

Cecil Co., Md.

16. Informant.....

Rebecca E. Vannort

Address

Port Deposit, Md.

17. Burial

Date thereof Oct. 3, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hopewell

Location

Port Deposit, Md., Rural

18. Funeral director

Loy A. Patterson & Son  
Terryville, Md.

Address

Oct. 3

1946

Drew Edgerton

(Date rec'd by registrar)

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Cecil

City or town..... Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Main

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

9-30

1946, at 9 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July

1946,

to

9-30

1946

and that I last saw him alive on

9-30

1946

Immediate cause of death.....

Cardiac Failure

DURATION

24 hrs.

Due to..... Cancer of lower colon  
with extensive metastasis

1 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Port Deposit, Md.

Date signed

9-30-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 5-16

## CERTIFICATE OF DEATH

08955

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred

Union Hosp.How long in hospital or institution? Sept 19 / 1946 to Oct 17 / 1946

## 3. (a) FULL NAME

Wilson - Glo

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleCalMarried6.(b) Name of husband or wife Mary M. Wilson

7. Birth date of deceased (mo., day, yr.)

Nov 9 - 1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Elkton Md

(Town, county, and state)

10. Usual occupation

Labor

11. Industry or business

Gas Works

12. Name

Elkton Md

13. Birthplace

Hennetta Cork

14. Maiden name

Kent Co - Maryland

15. Birthplace

Rose Leaf

16. Informant

117 Clinton St. Elkton Md.

Address

BurialDate thereof Sept 20 '46

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Providence Cemetery

Cemetery or crematory

Elkton Md.

Location

Edwin A. Well

18. Funeral director

909 Poplar St. Wilkes-Barre

Address

Sept 19 1946

Date rec'd by registrar

J. H. Frazer

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Elkton Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

141 Collins St

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 17 -1946 at 1205 1/421. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24, 1946, to Sept 17, 1946, and that I last saw him alive on Sept 16 - 1946.

Immediate cause of death

Cerebral Failure

DURATION

Due to Surgical operation9/13/46Due to PeritonectomyOther conditions Carcinoma of Prostate

(Include pregnancy, within 3 months of death)

Major findings of operations

Carcinoma of ProstateDate of op. 9/13/46Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

D. A. Campbell 419

M. D. or other

Address North East, Md Date signed 9/17/46

